DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/03/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185187	A. BUILDING _____ B. WING _____	10/22/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRITTHAVEN OF BOWLING GREEN	5079 SCOTTSVILLE RD BOWLING GREEN, KY 42104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An annual survey and abbreviated surveys (KY #15343, KY #15344, KY #15345, KY #15346, KY# 15347, KY #15348, KY #15366 and KY #13478) were conducted 10/19/10 through 10/22/10 to determine the facility's compliance with Federal requirements. The facility failed to meet requirements for recertification with the highest S/S of "D". KY #15343, KY #15344 and KY #15366 were unsubstantiated. KY #15345, KY #15346 and KY #15478 were substantiated with no deficiencies cited. KY #15347 and KY #15348 were substantiated with deficiencies cited.	F 000	Britthaven acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as	F 157	Britthaven's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Britthaven reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure, and/or any other administrative or legal proceeding.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Jonathan M Gunn | Administrator | 11/16/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to immediately notify the resident's responsible party for one resident (#4) in the selected sample of 24 and one resident (#27) not in the selected sample. Residents #4 and #27 had skilled services discontinued without notification of the residents' Power of Attorneys. Findings include: 1. A record review revealed Resident #10 was admitted to the facility with diagnoses to include Alzheimer's Dementia and Parkinson's Syndrome. A review of the quarterly MDS assessment, dated 08/03/10, revealed the facility assessed the resident's cognition to be moderately impaired for daily decision making. Resident #10 was not interviewable. A review of the Durable Power of Attorney, dated 03/16/04, revealed the resident had a Power of Attorney (POA) to manage financial decisions. A review of the "Notice of Medicare Provider Non-Coverage" letter, dated 05/26/10, revealed Resident #10's skilled services would be	F 157	F-157 ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** Resident #4 and #27 are no longer on a Medicare stay, A demand bill was processed for both on 9/27/2010 which proves they exercised there right to appeal the medicare decision, Resident #10 has not had a Medicare stay in 2010 ***How will you identify other residents having the potential to be affected by the same deficient practice.*** An Audit was conducted on 11/12/10 of all residents currently receiving Medicare benefits to verify that the POA and / or Responsible party was made aware of the Medicare Discontinuance and right to Appeal process.	

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F 157	Continued From page 2 discontinued on 06/17/10. The resident had signed the letter. There was no documentation the POA had been notified. 2. A record review revealed Resident #27 was admitted to the facility with diagnoses to include Alzheimer's Dementia and Depression. A review of the quarterly MDS assessment, dated 08/20/10, revealed the facility assessed the resident's cognition to be moderately impaired. Attempts to interview the resident were unsuccessful. A review of the Durable Power of Attorney, dated 03/16/04, revealed the resident had a POA to manage financial decisions. A review of the "Notice of Medicare Provider Non-Coverage" letter, dated 06/03/10, revealed Resident #27's skilled services would be discontinued on 06/12/10. The resident had signed the letter with an "X" and the signature was witnessed by a facility employee. There was no documentation the POA had been notified. An interview with Residents #10 and #27's POA, on 10/22/10 at 2:30 PM, revealed she was not notified of the discontinuation of skilled services until she received a statement in the mail. An interview with the Activity Director, on 10/21/10 at 2:20 PM, revealed she was responsible for "skilled services being terminated". She stated she had residents sign the Notice of Medicare Provider Non-Coverage letters and the Admission Office called and notified the families. An interview with the Admissions Coordinator, on	F 157	***What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur.*** On 11/8/2010 Facility Administrator re-inserviced the Bookkeeper, Assistant Bookkeeper, Admissions Coordinator, and Activity Director on how to complete the Notice of Medicare Provider Non-coverage Form which informs the POA / responsible party of the day Skilled Services will stop and how to appeal and contact Health Care Excel for a appeal request if desired. Facility will have POA or Responsible party sign the Form or document on the form the Date and time they were made aware of the day that benefits will end and their right to appeal the facility deterimination. ***Indicate how the facility plans to monitor its performance to ensure that solutions are sustained;*** A Monthly Q/I will be completed by the Administrator to verify that the Notice of Medicare Provider Non-coverage letter has been completed	

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F 157	Continued From page 3 10/21/10 at 2:35 PM, revealed she was responsible for notifying the families when residnts "came off Medicare". She stated the residents' POAs visited every day in the facility, which included stopping by her office, and were informed "numerous times" regarding the Medicare non-coverage. She stated the POAs did not sign the Notice of Medicare Provider Non-Coverage letters. There was no documentation that the POAs had received information regarding Medicare non-coverage.	F 157	correctly and POA / Responsible party was notified. The results of these audits will be reviewed in the monthly Executive Q/I committee meeting with the Administrator, D.O.N., and Medical Director. ***When the corrective action(s) will be completed for each deficiency;*** Completion date – 11/30/10	11/30/10
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure the environment was as free of accident hazards as was possible and adequate supervision was provided to prevent accidents, for one resident (#3), in the selected sample of 24. Resident #3 sustained a fall from a shower chair with one staff member present. The resident sustained a small laceration above the eye, which required sutures. The staff member left the resident's side to summon assistance with the transfer of the resident from the shower chair to a geri-chair. The resident's shower chair seatbelt was not secured and the resident attempted a self	F 323	F323 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident # 3's care plan was amended to include the use of a reclining back shower chair with a safety belt for the resident's comfort and safety. This resident's care plan was also amended to have the actual transfer of the resident to and from the shower chair to take place in the resident's room, using a patient lift and two staff members. The completion date was 08-12-10.	

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F 323	Continued From page 4 transfer. Findings include: A review of the facility policy, "Reporting and Investigation of Resident Events and Incidents", dated 1/2009, revealed facility staff were required to complete a Resident QI Reporting form, in the event of an incident/event. A record review revealed Resident #3 was admitted to the facility with diagnoses to include Cerebrovascular disease, Vascular Dementia, and Aphasia. A review of the Fall Risk Evaluation, dated 05/22/10, revealed the facility assessed Resident #3 as at high risk for falls. A review of the annual Minimum Data Set (MDS), dated 08/02/10, revealed the facility identified Resident #3 as moderately cognitively impaired and required extensive assistance of two staff members for transfers and total dependence on two staff members for bathing. A review of the Comprehensive Care Plan, dated 08/12/10, for the problem "Potential to restore or maintain maximum function for bathing", revealed interventions included total dependence on one staff member for bathing and transfer utilizing a mechanical lift. A review of the Certified Nursing Assistant (CNA) care guide revealed Resident #3 was totally dependent on staff for dressing and transfers were provided using a mechanical lift. However, the number of staff needed was not identified. The care guide did not address bathing/showering and the number of staff needed to provide a shower. An interview with Licensed Practical Nurse (LPN) #4, on 10/19/10 at 12:35 PM, revealed she was on duty, on 08/11/10, when Resident #3 sustained a fall in the shower room. She stated	F 323	**How will you identify other residents having the potential to be affected by the deficient practice;** All residents have the potential to be affected by this deficient practice. **What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur;** In-services are being conduct by our SDC for all nursing staff members; The content of the in-services are as follows: safety in the shower room is top priority, which includes safety belts are securely fastened in place, on each resident in a shower chair, call lights are easily reached and that a resident is never outside the reach of the staff member when in the shower chair; the resident is never left unattended while in the shower chair. The in-services will be completed by 11-25-10	

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F 323	Continued From page 5 she overheard CNA #2 yell for assistance and then yell, "No"! She observed Resident #3 lying on the floor and the CNA was craddling the resident's head in her lap. There was a small amount of blood oozing from the resident's right eyebrow. The CNA was instructed to apply pressure to the laceration and LPN #4 provided neuro-checks. She notified the physician, Emergency Medical Systems (EMS) and the family. An interview with CNA #2, on 10/21/10 at 10:44 AM, revealed Resident #3 was bathed by one staff member and transferred with a mechanical lift by two staff members. She had finished providing the resident's bath and dressed Resident #3. She needed a second staff member for the resident's transfer to a geri-chair, using a lift. She had used the call light but staff did not respond. She left the resident's side for a moment to summon assistance and at the time, the resident made an attempt to transfer and fell. The shower chair seatbelt was applied, but was not secured. CNA #2 stated the shower chair seatbelt was difficult to secure and had to be "jammed in" to lock. The resident fell face first onto the floor. An interview with LPN #1, on 10/22/10 at 9:30 AM, revealed she completed an investigaion of the incident and determined the cause of the accident was due to the CNA had not checked the plastic clasp on the seatbelt to ensure it was secure. The mechanical lift was not in the shower room, making it necessary for CNA #2 to request the lift and the CNA left the resident alone, to summon assistance to transfer the resident with the mechanical lift.	F 323	**Indicate how the facility plans to monitor its performance to ensure that solutions are sustained;** The Unit coordinators will monitor the use of safety belts while the residents are in the shower chair. The results of the audit will be submitted to the Q/I Coordinator. The Q/I Cord. will compile the information from all units monthly. The results of the audits will be reviewed in the monthly Executive Q/I meeting and analyzed for trends; any identified issues will be addressed as indicated. The Administrator, D.O.N., and Medical Director attend the monthly Q/I meetings. **When the corrective action(s) will be completed for each deficiency;** The completion date is 11-30-10	11/30/10

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F 323	Continued From page 6 An interview with the Director of Nursing (DON), on 10/22/10 at 10:30 AM, revealed she was not employed by the facility at the time of the incident. The DON stated it would have been best if the aide checked and made sure the clasp was latched.	F 323		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	F441 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Certified Nursing Assistant #12 was counseled and re-in-service on the appropriate hand washing and the appropriate time to change the gloves while providing personal care/incontinent care to the residents. This was completed on 10-21-10. **How will you indentify other residents having the potential to be affected by this deficient practice;** All residents have the potential to be affected by this deficient practice.	

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F 441	Continued From page 7 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record review, it was determined the facility failed to ensure staff washed their hands after each direct resident contact for which hand washing was indicated by accepted professional practice for one resident (#10) in the selected sample of 24. Findings include: A review of the "Handwashing Policy", dated August 2005, revealed personnel were to wash their hands after each direct or indirect resident contact for which handwashing was indicated by acceptable standards of practice. The policy revealed personnel should wash their hands after contact with blood, body fluids, secretions, excretions, and equipment or articles contaminated by them. Handwashing should also occur when hands were visibly or obviously soiled. A record review revealed Resident #10 was admitted to the facility on 08/25/09. A review of the annual Minimum Data Set (MDS), dated 08/06/10, revealed the facility identified Resident #10 as moderately cognitively impaired and required extensive assistance with bed mobility and transfers. The MDS revealed the resident was incontinent of bowel and bladder. An observation of incontinent care, on 10/21/10 at	F 441	**What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur;** On 10-28-10 written handouts were distributed to all staff members and a signed roster acknowledging the receipt of the handout, which addressed our hand washing policy and the appropriate use of personal protective equipment (gloves) when providing personal/incontinent care. On 10-29-10 we began in-service with return demonstrations by every staff member utilizing UV disclosing lotion, hands that have not been washed effectively will show up under the "black light" . The black light reveals what lotion or "germs " are left behind, the light also demonstrates the spread of possible contamination on their clothing or other objects touched with contaminated gloves or hands. In-services will be completed by 11-25-10.	

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F 441	Continued From page 8 10:05 AM, revealed Certified Nurse Aide (CNA) #12 provided care after the resident had been incontinent of bowel. CNA #12 cleansed the resident's buttocks and applied a moisture barrier cream. After incontinent care was provided, CNA #12 applied a nasal cannula into the resident's nose before removing her soiled gloves. An interview with CNA #12, on 10/21/10 at 10:15 AM, revealed she should have removed her gloves and washed her hands after incontinent care was provided to Resident #10. She stated, "I do change my gloves if they are messy." She revealed there was no feces on her gloves but knew she should have changed her gloves before replacing the oxygen cannula in the resident's nose. An interview with the Director of Nursing, on 10/21/10 at 3:20 PM, revealed she expected staff to wash their hands after contaminating their hands. She stated, "It is a definite problem to put a nasal cannula in a resident's nose while wearing soiled gloves."	F 441	**Indicate how the facility plans to monitor its performance to ensure that the solutions are sustained;** We will randomly conduct Resident Care Audits "Hand washing Post Incontinent Care" for all nursing staff. House supervisors, unit coordinators, Q/I and SDC personnel to conduct audits monthly. Audits submitted to SDC, for review at weekly Infection Control meetings, and ultimately presented at the monthly Executive Q/I Meeting with the Administrator, D.O.N. and Medical Director. Any trends noted will be addressed as indicated. **When the corrective action(s) will be completed for each deficiency;** Completion date will be 11-30-10	11/30/10

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K 000	INITIAL COMMENTS A life safety code survey was initiated and concluded on 10/19/2010. The facility was found not to meet the minimal requirements with 42 code of the Federal Regulations, Part 483.70. The highest scope and severity deficiency identified was an "F".	K 000	Britthaven acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Britthaven's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Britthaven reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure, and/or any other administrative or legal proceeding.	
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure approved doors were used in smoke barriers. Doors used in smoke barriers must be of an approved type to limit the spread of smoke and fire. The deficiency affected (6) smoke compartments and (106) residents of the facility. The findings include: An observation on 10/19/2010 at 11:18 AM, revealed an unapproved door in the attic smoke barrier of the 200 Hall front section. Further observations revealed the same for the 200 hall, back section, 300 hall, front section, and 300 hall, back section. The observations were confirmed	K 025		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Jonathan McGuire | Administrator | 11/8/10

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K 025	Continued From page 1 with the Maintenance Director. An interview, on 10/19/2010 at 11:18 AM, with the Maintenance Director, revealed the unapproved doors had been there since he started working at the facility (5) years ago. Reference: NFPA 80 (1999 edition) 11-1 Doors. 11-1.1 General. This chapter shall cover the installation of both horizontal and vertical access doors in fire-rated walls, floors, and floor-ceiling or roof-ceiling assemblies. 11-1.2 Components. An access door shall be an integral unit including the door, frame, hinges, latch, and closing device (where required) bearing a label that reads " Frame and Fire Door Assembly. " Exception: A vertical access door shall be permitted to have hinges that are not part of the labeled assembly, provided the hinges conform to Table 2-4.3.1. 11-1.2.1 Access doors shall be self-closing. 11-1.2.2 Access doors shall be self-latching. Exception: A horizontal access door that does not open downward and that remains in place when an upward force of 1 psf (48 N/m2) is applied over the entire exposed surface of the door shall not be required to be self-latching. 11-1.2.3 Self-closing access doors that are intended to be used to allow a person to enter the concealed space behind the door completely shall be operable from the inside without the	K 025	K-025 Western Kentucky Windows and Doors have been contracted to install new fire rated attic smoke doors. Comstar Systems have been contacted to inspect and verify that facility Attic doors are in requirement with Life Safety code K-025 Maintenance staff has been re-in serviced by the Administrator on 11/16/10 on the requirements of K-025. Maintenance director will do a monthly Q/I to verify that the facility does have the approved type doors in smoke barrier wall for attic use. The results of these audits will be reviewed in the monthly Executive Q/I committee meeting for the next 3 months with the Administrator, D.O.N, and Medical Director. Completion Date 11/30/10	11/30/10

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	185187	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/19/2010

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K 025	Continued From page 2 use of a key or tool. 11-1.2.4 Access doors shall be installed in accordance with their listing. 11-2.2 Vertical Access Doors. 11-2.2.1 Vertical access doors shall have a fire protection rating of 3/4 hour, 1 hour, or 11/2 hours. (See Appendix F.) 11-2.2.2 Vertical access doors shall be used only in walls. 11-2.2.3 Where the authority having jurisdiction determines that a vertical access door is located in proximity to combustibles so that, in a fire condition, the door is likely to transmit sufficient heat to ignite the combustibles, the temperature rise on the unexposed face of the door shall not exceed 250°F (139°C) at the end of a 30-minute exposure to the standard fire test as described in NFPA 252, Standard Methods of Fire Tests of Door Assemblies. Such an access door shall bear a label indicating a maximum temperature rise of 250°F (139°C). 11-2.2.4 Closing by means of gravity using top-hinging vertical access doors shall be permitted to meet the requirements for self-closing doors. 11-2.2.5 A vertical access door shall bear a label that includes the additional wording " For Vertical Installation. "	K 025	K-047 The facility Maintenance Director connected Exit sign in kitchen to electrical power source and emergency generator. Facility has contacted Comstar Systems to inspect and verify that Exit sign is connected. Maintenance staff has been re-in serviced by the Administrator on 11/16/10 on the requirements of K-047. Maintenance director will do a monthly Q/I to verify that all exits	
K 047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in	K 047	sign are working and have power to them. The results of these audits will be reviewed in the monthly	

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K 047	Continued From page 3 accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit signs were maintained according to NFPA standards. Exit signs must be maintained to ensure exits are identifiable in an emergency. The deficiency affected all staff in the kitchen area. The findings include: An observation on 10/19/2010 at 12:37 PM, revealed the exit sign for the kitchen was not illuminated. The observation was confirmed with the Maintenance Director. An interview, on 10/19/2010 at 12:37 PM, with the Maintenance Director, revealed the sign had never been hooked to the emergency generator. Reference: NFPA 101 (2000 edition) 7.10.1.2* Exits. Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access.	K 047	Executive Q/I committee meeting for the next 3 months with the Administrator, D.O.N, and Medical Director. Completion Date 11/30/10	11/30/10
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052	K-052 Facility had Comstar Systems to perform the required Sensitivity test on the 2 smoke detectors on 10/23/2010. Comstar Systems have been contracted to do the Bi-annual Detector Sensitivity testing which is schedule for 2011 for all Detectors per last schedule inspection.	

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K 052	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation, record review and interview, it was determined the facility failed to ensure smoke detectors had sensitivity testing conducted according to NFPA standards. Smoke detectors must have sensitivity testing conducted to ensure they will react to smoke during a fire. The deficiency affected (50) residents and (2) smoke compartments. The findings include: Record review of the smoke detector sensitivity on 10/19/2010 at 2:10 PM, revealed that (2) smoke detectors installed on 12/03/2007 had never had sensitivity testing conducted on them. This was confirmed with the Maintenance Director. An interview, on 10/19/2010 at 2:10 PM, with the Maintenance Director, revealed he was unaware of the two detectors needing sensitivity testing. Reference: NFPA 72 (1999 edition) R 7-3.2.1* Detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity	K 052	Maintenance staff has been re-in serviced by the Administrator on 11/16/10 on the requirements of K-052. Maintenance director will do a monthly Q/I to verify that the Detector Sensitivity testing has been done on all detectors. The results of these audits will be reviewed in the monthly Executive Q/I committee meeting for the next 3 months with the Administrator, D.O.N, and Medical Director. Completion Date 11/30/10	11/30/10

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K 052	Continued From page 5 range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector-caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods: (1) Calibrated test method (2) Manufacturer ' s calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. Exception No. 1: Detectors listed as field adjustable shall be permitted	K 052		

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K 052	Continued From page 6 to be either adjusted within the listed and marked sensitivity range and cleaned and recalibrated, or they shall be replaced. Exception No. 2: This requirement shall not apply to single station detectors referenced in 7-3.3 and Table 7-2.2. The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of smoke or other aerosol into the detector.	K 052	K-062 Facility had Eagle Fire Protection to replace all gauges on the facility sprinkler system on October 22, 2010. Eagle Fire Protection has been contracted to do the 5 year sprinkler inspection and replacement of all	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure sprinklers were maintained according to NFPA standards. Sprinklers must be maintained to ensure the sprinkler system operates during a fire. The deficiency affected all staff and residents. The findings include: Record review of the sprinkler inspection form, on 10/19/2010 at 1:54 PM, revealed there was no documentation of the gauges for the sprinkler system being replaced or recalibrated at (5) year intervals. An interview, on 10/19/2010 at 1:54 PM, with the Maintenance Director, revealed he was unsure if the gauges of the sprinkler system had been replaced or recalibrated at (5) year intervals.	K 062	gauges. Maintenance staff has been re-in serviced by the Administrator on 11/16/10 on the requirements of K-062. Maintenance director will do a monthly Q/I to verify that the Gauge has been replaced and working correctly. The results of these audits will be reviewed in the monthly Executive Q/I committee meeting for the next 3 months with the Administrator, D.O.N, and Medical Director. Completion Date 11/30/10	11/30/10

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K 062	Continued From page 7 Reference: NFPA 25 (1998 edition) 2-3.2* Gauges. Gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced.	K 062	K-072 Facility has remodeled closets & nurse stations so that all Lifts and Nurse Medication carts can be stored out of the hallway when not in use. All Facility staff has been re-in serviced by the Staff Development Coordinator by 11/29/10 on the requirements of K-072. Maintenance director will do a weekly Q/I to verify that the Facility hallways are clear of Lifts and Medications carts for storage. The results of these audits will be reviewed in the monthly Executive Q/I committee meeting for the next 3 months with the Administrator, D.O.N, and Medical Director. Completion Date 11/30/10	11/30/10
K 072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that corridors were maintained free from obstructions to full instant use in the case of fire or other emergency. Exits must be maintained to ensure their use in an emergency. The deficiency affected all residents. The findings include: An observation on 10/19/2010 at 12:29 PM, revealed (1) medicine cart not in use, parked in front of the 100 Hall nurse's station. Further observation revealed medicine carts not in use, parked at the 200 Hall nurse's station and the 300 Hall nurse's station. Patient lifts where observed in the 200 Hall near resident rooms #206 and #218, the 300 Hall near resident room #318 and not is use. The observation was confirmed with the Maintenance Director. An interview, on 10/19/2010 at 12:29 PM, with the	K 072		

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K 072	Continued From page 8 Maintenance Director, revealed the carts were routinely left in the halls due to lack of storage space, but the facility was trying to address the problem by using a room on the 300 Hall corridor as storage. Reference: NFPA 101 (2000 edition) 7.1.10 Means of Egress Reliability. 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 072	K-076 Facility has removed the Air unit from the Oxygen storage room on 10/21/2010	
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure sources of ignition were limited in oxygen supply rooms. Sources of ignition must be limited in areas where oxygen is present to prevent fires. The deficiency affected (1) smoke compartment. The findings include:	K 076	GMS was contracted to install and repair the brick wall where the Air Unit was removed on 10/22/10. Maintenance staff has been re-in serviced by the administrator on 11/16/10 on the requirements of K-076. Maintenance director will do a monthly Q/I to verify that the Oxygen room is in compliance with K-076 with No Air unit in Room. The results of these audits will be reviewed in the monthly Executive Q/I committee meeting for the next 3 months with the Administrator, D.O.N, and Medical Director. Completion Date 11/30/10	11/30/10

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K 076	Continued From page 9 An observation on 10/19/2010 at 12:44 PM, revealed the oxygen supply room had an air conditioning and heating unit located within the oxygen supply room. The observation was confirmed with the Maintenance Director. An interview, on 10/19/2010 at 12:44 PM, with the Maintenance Director, revealed he thought the air conditioner and heater unit were "ok" in the oxygen supply room. Reference: NFPA 99 (1999 edition) 8-2.1.2.4 Sources of ignition include not only the usual ones in ordinary atmospheres, but others that become significant hazards in oxygen-enriched atmospheres (see 8-2.1.2.1) such as the following: (d) Electrical equipment not conforming to the require ments of 7-6.2.4.1, which can include, but is not limited to, electric razors, electric bed controls, hair dryers, remote televi sion controls, and telephone handsets, can create a source of ignition if introduced into an oxygen-enriched atmosphere (see 7-6.2.4.1).	K 076	K-147 Facility Maintenance Director has installed locks to all electrical panel boxes.	
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was	K 147	Comstar Systems will be contacted to inspect that all Electrical Panels are locked. Maintenance staff has been re-in serviced by the administrator on 11/16/10 on the requirements of K-147.	

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K 147	Continued From page 10 determined the facility failed to ensure electrical panels, located in the hallway corridors of the facility, were secured to prevent residents from accessing the electrical panels. Electrical panels must be secured to prevent injuries to the residents. The findings include: An observation, on 10/19/2010 at 11:45 AM, revealed (3) electrical panels on the 100 Hall corridor that were not locked. Further observation, during the Life Safety Code survey, revealed (3) electrical panels on the 200 Hall corridor, and (3) electrical panels on the 300 Hall corridor were not locked. The observation was confirmed with the Maintenance Director. An interview, on 10/19/2010 at 11:45 AM, with the Maintenance Director, revealed the electrical panels were never locked. Reference: NFPA 70 (1999 edition) 110-26. Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained about all electric equipment to permit ready and safe opera tion and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.	K 147	Maintenance director will do a monthly Q/I to verify that the Electrical panels are locked. The results of these audits will be reviewed in the monthly Executive Q/I committee meeting for the next 3 months with the Administrator, D.O.N, and Medical Director. Completion Date 11/30/10	11/30/10